AMERICAN MEDICAL ACADEMY

Park Tower Beach Business Center
5150 E. Pacific Coast Hwy, Suite 200, Long Beach, CA 90804
Toll Free (866) 406-9522 Phone (562)-936-0062 Fax (866) 936-0461
Email: info@AmericanMedicalAcademy.org Web Site: www.AmericanMedicalAcademy.org

Clinical Laboratory Scientist / Medical Laboratory Technician

REVIEW PROGRAM - REGISTRATION FORM

Name: _____
Last First Middle Name

Address: _____
Street City State Zip Code

Telephone No: _____ Mobile No.: _____ Work No.: _____

Time to Call: _____ Email: _____

Are You Currently Employed: ☐ YES ☐ NO Employer: _____

EDUCATION BACKGROUND

Please fill out all questions and indicate N/A in areas that are not applicable.

A. COLLEGE / UNIVERSITY:

NAME OF SCHOOL *(List the most recent)*	State/ Country	Year of Graduation	Diploma / Degree

B. GRADUATE SCHOOL:

NAME OF SCHOOL	State/Country	Year of Graduation	Diploma / Degree
If Graduate Studies has not been completed, please indicate the number of units earned to date:			

C. OTHER TRAINING EXPERIENCE (IF APPLICABLE):

Type of Training *(List the most recent)*	City / State	Year of Graduation	Diploma / Degree *(Major / Minor of Studies)*

EMPLOYMENT HISTORY

Name of Employer	Employment Dates		Summarize the Type of Work Performed and Job Responsibilities
Address	From	To	
Job Title			

Name of Employer	Employment Dates		Summarize the Type of Work Performed and Job Responsibilities
Address	From	To	
Job Title			

Name of Employer	Employment Dates		Summarize the Type of Work Performed and Job Responsibilities
Address	From	To	
Job Title			

OTHER INFORMATION: (The following information will assist us in determining your exam preparation needs).

Have you previously attended a formal review class? ☐ YES ☐ NO If YES, please answer the following:

Name of Review Center: _____ City / State: _____

List any expectations you may have regarding "live" review class instructions?

_____

_____

List your weakest subject(s) that you would like more instruction focus.

_____

List your strongest subject(s).

_____

Please tell us how you heard of our review programs: ☐ Advertisement ☐ Website ☐ Search Engine _____

☐ Friend _____ ☐ School _____

Note: All information provided herein shall be handled in strict confidence and used solely for American Medical Academy's enrollment purposes and educational review program curriculum

Signature: _____ Date: _____

Please print and mail completed registration
along with your check for the amount of $950 to:

Checks should be made payable to:

AMERICAN MEDICAL ACADEMY

American Medical Academy
Park Tower Beach Business Center
5150 E. Pacific Coast Hwy., Suite 200
Long Beach, CA 90804

For additional inquiries, please contact us at: ***(866) 406-9522 / (562) 936-0062*** or ***info@AmericanMedicalAcademy.org***
You may also visit our website at: ***www.AmericanMedicalAcademy.org***